NOTICE OF FORM CHANGE NO. 03-113

DATE: 8/20/03

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

☐ Community Care Licensing District Offices
☐ District Attorney
☐ Private and Public Adoption Agencies
☐ Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE

SOC 332 (8/03) In-Home Supportive Services Recipient/Employer Responsibility Checklist

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
MASTER ONLY	☒ Free ☐ Sold		☐ Yes ☒ No
☐ New ☒ Revised	DATE OF FORM: 8/03	REPLACES: 5/00	☐ Obsolete

REQUIRED FORM-
☒ No Change Permitted
REQUIRED FORM-
☐ Substitute Permitted With Prior DSS Approval
☐ Recommended Form

UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT:

Department of Social Services Warehouse
P.O. Box 980788
West Sacramento, CA 95798-0788

☐ OTHER:

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY
☒ Use until exhausted
☐ Destroy

USE NEW FORM
☐ When supply available in DSS Warehouse
☒ Use new form effective when old supply is exhausted.

USE FORM IN ACCORDANCE WITH
☐ All County Letter No.
☐ Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached is a Reproducible Copy

Check on the Internet to see if forms are available at www.dss.cahwnet.gov.

For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov. Contact Language Services for other languages at (916) 445-6778 or by electronic mail at LTS@dss.ca.gov.

IN-HOME SUPPORTIVE SERVICES
Recipient/Employer Responsibility Checklist

I, ____ , HAVE BEEN INFORMED BY MY WORKER THAT AS A RECIPIENT/EMPLOYER, I AM RESPONSIBLE FOR THE ACTIVITIES LISTED BELOW.

1) To find, hire, train, supervise, and fire the provider(s) I employ.

2) To verify that my provider(s) is legally residing in the United States. I must complete an I-9 for my provider(s) and retain the I-9 for (3) years.

3) To ensure standards of compensation, work scheduling and working conditions for my provider(s).

4) To provide my worker with the following information regarding my provider(s), and any future change in my provider(s).

__ Name
__ Address
__ Social Security Number
__ Date of Birth*
__ Ethnicity*
__ Primary Language*
__ Telephone Number
__ Relationship to me, if any
__ Hours to be worked and services to be performed by each provider

*Please provide this information if it is available to you.

5) To inform my provider(s) that the hourly rate of pay is $______________________, gross and that Social Security and State Disability Insurance taxes may be deducted from the payment.

6) To inform my provider(s) that they may request that Federal or State Income Taxes be deducted from the payment and he/she will be sent a Form W-2 Wage and Tax Statement at the end of January for income tax filing.

7) To inform my provider(s) that he/she may be covered by Workers' Compensation, State Unemployment Insurance benefits, and State Disability Insurance benefits.

8) To inform my provider(s) of the services authorized and the time given to perform authorized services.

9) To pay my share of cost, if any, directly to my provider(s) or directly to the county social services department.

10) To verify and sign my provider(s) timesheet for each pay period showing the correct day and the correct total number of hours worked.

11) To ensure my provider(s) signed his/her timesheet.

12) To advise my provider(s) to mail his/her signed timesheet to the appropriate county social services department at the end of each pay period.

13) To comply with laws and regulations relating to wages/hours/working conditions and hiring of persons under age 18.

NOTE: Refer to Industrial Welfare Commission (IWC) Order Number 15 regarding wages/hours/working conditions obtainable from the State Department of Industrial Relations, Division of Labor Standards and Enforcement listed in the telephone book. Additional information regarding the hiring of minors may be obtained by contacting your local school district.

* *

I HAVE EXPLAINED THE RESPONSIBILITIES LISTED ON THIS FORM TO THE IHSS RECIPIENT.

Worker	Telephone	Date
Recipient		Date
Provider		Date

INSTRUCTIONS FOR USE OF THE RECIPIENT/EMPLOYER RESPONSIBILITY CHECKLIST

1. This form is recommended for review with recipients receiving service from Individual Providers **only**.
2. Counties may use this form to assure that recipients have been advised of and understand their basic responsibilities as employers of IHSS providers.
3. Review each item with the recipient and explain how the recipient can comply with each requirement.
4. Sign and date the form.
5. Leave a copy of the form with the recipient.